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| --- | --- |
| Clinic Name  |       |
| Address  |       |
| Phone number |       |

 | **Work Rehabilitation****Initial Evaluation**  |
| Worker Name:      | Date of Report:      | Claim Number(s):      |
| Accepted Conditions:       | Date of Injury:      | Date of surgery: [ ]  NA      |
| Attending/Referring Provider:       | Next AP appointment Date:       [ ]  Unknown |
| Job Goal:       | Physical Demand Level of Job Goal:       |
| Vocational Provider:       | Job Analysis/Description provided? [ ]  Yes [ ]  No |
| Review by client? [ ]  Yes [ ]  No |
| Current Work Status: [ ] Full-Duty [ ] Modified/Light-Duty [ ] Not Working [ ] Other:       |
| Worker’s Goals for this program:      |
|  |
| **Current Capacity** |
| **Demonstrated current positional tolerances**:    Hours per day    Total hours per week |
| **Sit** for |       at a time;    Hours per day | **For combined activities of sit/stand/walk or stand/walk, 2 hours in an 8-hour day is considered within normal limits**. |
| **Stand** for |        at a time;    Hours per day | Alternately **stand/walk**       at a time;    Hours per day |
| **Walk** for |        at a time;    Hours per day | Alternately **sit/stand/walk**       at a time;    Hours per day |
| Observations:       |
|  |
| **GROSS MOBILITY/ POSITIONAL ASSESSMENTS:** *(R= Right; L= Left; B= Both)* **Hand Dominance: R L** |
| Task | Current weight/frequencyS, O, F, C, NT | Clinical Observations: *describe body mechanics, barrier to movement patterns or other restrictions* | Job Goal weight/frequencyS, O, F, C, NT |
| Climb: Ladder/Stairs |       /    |       |       /    |
| Twist Neck |       /     |       |       /    |
| Twist Trunk |       /    |       |       /    |
| Bend/Stoop |       /    |       |       /    |
| Kneel |       /    |       |       /    |
| Squat |       /    |       |       /    |
| Reach: Forward |       /    |       |       /    |
| Reach waist to shoulder |       /    |       |       /    |
| Work above shoulders |       /    |       |       /    |
| Grasp (Forceful) |       /    |       |       /    |
| Handle/Grasp |       /    |       |       /    |
| Fine manipulation |       /    |       |       /    |
| Lift |
| Floor to Waist |       /    |       |       /    |
| Waist to Shoulders |       /    |       |       /    |
| Shoulder to Overhead |       /    |       |       /    |
| Carry |       /    |       |       /    |
| Push/Pull |       /    |       |       /    |

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| **Job Specific Testing:** *Example: Keyboarding, ladder carry, rope pull* |
| Task 1:             |       |
| Task 2:       |       |
| **Comments:**       |
|  |
| **Aerobic Capacity** (*treadmill, step test, TUG)* | **Score/METS** | **Findings consistent with Physical Demand level:** *Sedentary, Light, Medium, Heavy* |
|       |       |       |
| Comments:       |
|  |
| **Self-reported functional outcome measures** |
| Examples: *Oswestry Neck Disability Index; Quick DASH; LEFS; Functional Reach Test* | **Score** | **Result Interpretation** |
|       |       |       |
|       |       |       |
|       |       |       |
|  |
| **Barriers and Strategies for Recovery** |
| Describe any barriers identified that may impede recovery?       |
| Identify strategies and suggestions to address barriers:       |
|  |
| **Treatment Plan & Signature** |
| What WR program is recommended: [ ]  Work Rehabilitation – Conditioning [ ]  Work Rehabilitation - Hardening Anticipated WR Treatment Start Date:       |
| [ ]  Not a candidate for WR Program. Comments:       |
| Initial Frequency and Duration |   days/week for    weeks |  Starting at   hours/day |
| **Goals:** Progressive over program and reflect changes in functional abilities and duration based on job goal. *Examples: Occasional lifting floor to waist will increase from 20# to 40# in 2 weeks. Static standing will increase from 10 min to 30 min in 2 weeks.* |
| 1.       |
| 2..      |
| 3.       |
| 4.       |
| Plan of Care reviewed with Client [ ]  Yes [ ]  No  |
| Clinic Name:       | Clinic Fax Number:       | Clinic Phone Number:       |
| Therapist(s) Name, Credential | Therapist(s) NPI | Therapist(s) Signature | Date Signed |
|       |       |  |       |
| Therapist(s) Name, Credential | Therapist(s) NPI | Therapist(s) Signature | Date Signed |
|       |       |  |       |